BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of New Rules I through IV, and the amendment of ARM 37.85.406, 37.86.105, 37.86.205, 37.86.506, 37.86.2801, 37.86.2803, 37.86.2901, 37.86.2905, 37.86.2912, 37.86.2918, 37.86.2943, 37.86.2947, 37.86.3001, 37.86.3005, 37.86.3007, 37.86.3009, 37.86.3016, 37.86.3018, 37.86.3020, 37.86.3025, 37.88.206, 37.88.306, 37.88.606, and 37.88.1106 pertaining to Medicaid reimbursement of hospitals, provider based entities, and birthing centers	)	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION AND AMENDMENT

TO: All Interested Persons

1. On December 1, 2006, at 1:30 p.m., a public hearing will be held in the auditorium of the Department of Public Health and Human Services Building, 111 N. Sanders, Helena, Montana to consider the proposed adoption and amendment of the above-stated rules.

The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice or provide reasonable accommodations at the public hearing site. If you need to request an accommodation, contact the department no later than 5:00 p.m. on November 22, 2006, to advise us of the nature of the accommodation that you need. Please contact Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210; telephone (406)444-5622; FAX (406)444-1970; e-mail dphhslegal@mt.gov.

2. The rules as proposed to be adopted provide as follows:

RULE I PROVIDER BASED ENTITY SERVICES, GENERAL (1) For services provided on or after August 1, 2003, hospitals receiving provider based status from the Centers for Medicare and Medicaid Services (CMS) must send a copy of the CMS letter granting provider based status to the department's hospital program officer at Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951 and must receive department approval prior to billing as a provider based clinic.

(2) Medicaid does not allow self-attestation of provider based status.

(3) The provider based entity must provide the department a list of facilities, clinics, and all professional staff and their Medicaid provider numbers who will be billing provider based visits to Medicaid.

(4) Notification must be provided to the department within 30 days of staff changes.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, MCA

RULE II PROVIDER BASED ENTITY SERVICES, RECIPIENT ACCESS AND NOTIFICATION (1) Hospitals granted a provider based status by the department may not restrict access to Medicaid clients and must comply with antidumping rules in 42 CFR 489.20.

(2) A physician, clinic, or mid-level practitioner who practices primary care and is a provider based entity, except as described in (3) is required to participate in the Passport to Health and Team Care programs (ARM 37.86.5101 through 37.86.5120 and ARM 37.86.5201 through 37.86.5306). The provider:

(a) must sign a Passport to Health contract;

(b) must accept auto-assignment;

(c) must not limit or restrict acceptance of Medicaid clients unless that same limit/restriction applies to non-Medicaid clients;

(d) must set a Passport to Health caseload limit of at least 100 per physician or mid-level unless the department grants approval for a lower level; and

(e) can only disenroll clients from his/her caseload per the Passport to Health agreement and subject to approval by the department.

(3) A physician, clinic, or mid-level practitioner is exempt from the requirement to participate in the Passport to Health program if the following is met:

(a) the provider is not practicing primary care; or

(b) the provider has requested removal from the department and the department has granted approval.

(4) A clinic, physician, or mid-level practitioner who does not practice primary care and is a provider based entity is exempt from the requirement to participate in the Passport to Health program but is required to accept new Medicaid clients at the same rate no-nMedicaid clients are accepted.

(5) Recipients must be notified that they will be assessed two cost shares for Medicaid and/or two copayment and deductible charges for cross-over claims.

(a) Notices must be clearly posted in all clinics and facilities and the recipient must be provided written notice before the delivery of services as in 42 CFR 413.65(g)(7)(i), (ii), (iii), and (iv).

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, MCA

RULE III PROVIDER BASED ENTITY SERVICES, COMPLIANCE, AND PENALTIES (1) In the absence of compliance with any provider based entity requirements of [RULE I, II, or IV];

(a) the department will recover the difference between the amount of payments that were actually made to the provider based entity for both the professional and facility portions and the amount of payments that the department estimates should have been made to the professional only under ARM 37.86.105;

(b) the provider based entity may not bill as nor receive payment as a provider based entity until the department determines that the provider based entity is again in compliance with these rules;

(c) the provider may not continue to bill as a provider based entity after 30 days from the date of notice of determination of noncompliance;

(i) the department may terminate all payment to the provider, facility, or organization as of the date the department issued notice of noncompliance if the provider does not terminate billing as in (1)(c).

(2) A notice of failure of compliance with provider based entity status will be sent in writing to the provider based entity.

(a) If the department does not receive a response within 30 days after notification to the provider based entity, the department will make 100% payment deductions until full recovery is made. Recovery will be undertaken even though the provider disputes in whole or in part the department's determination of the overpayment and requests a fair hearing.

(b) The amount of any overpayment constitutes a debt due the department as of the date of initial request for payment and may be recovered from any person, party, transferee, or fiduciary who has benefited from either the payment or from a transfer of assets.

(3) Providers aggrieved by adverse determinations by the department may request an administrative review and fair hearing as provided in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, and 37.5.337.

AUTH: 53-6-101, 53-6-113, MCA
IMP: 53-6-101, MCA

RULE IV PROVIDER BASED ENTITY SERVICES, REIMBURSEMENT

(1) Reimbursement of the provider based entity facility component will be on a rate-per-service basis using the outpatient prospective payment system (OPPS) schedules or Medicare fee schedules as in ARM 37.86.3007, 37.86.3016, 37.86.3018, 37.86.3020, and 37.86.3025 except as follows:

(a) Provider based entity facility component billed under revenue code 510 will be reimbursed at 80% of the applicable rate.

(b) The facility component of provider based entities provided by exempt hospitals or critical access hospitals as defined in ARM 37.86.2901(4) and (8) will be interim reimbursed a hospital specific outpatient cost to charge ratio.

(2) Reimbursement of the provider based entity professional component will be reimbursed as provided in ARM 37.86.105, 37.86.205, 37.86.506, 37.88.206, and 37.88.606.

(3) Provider based entity facilities must bill using revenue code 510 for CPT codes for Evaluation and Management services (E and M codes) and procedural codes with the exception of laboratory services as in ARM 37.86.3007(3).

(4) Provider based entity professionals must bill using the correct site-of-service so that appropriate payment amounts may be determined as in ARM 37.86.105, 37.86.205, 37.86.506, 37.88.206, and 37.88.606.

(a) Unless otherwise noted, only CPT codes for Evaluation and Management

services and procedural codes may be billed for professional reimbursement in provider based entities.

(i) All other billable supplies, injectibles, drugs, imaging, diagnotics, lab, and any other services must be billed under the appropriate revenue code using the provider based entity facility provider number.

(5) Provider based entities providing obstretric services (which may include antepartum, delivery, and/or postpartum) must bill as a nonprovider based provider.

(6) Vaccines For Children (VFC) services must bill as a nonprovider based provider.

AUTH: 53-6-101, 53-6-113, MCA
IMP: 53-6-101, MCA

3. The rules as proposed to be amended provide as follows. Matter to be added is underlined. Matter to be deleted is interlined.

37.85.406 BILLING, REIMBURSEMENT, CLAIMS PROCESSING, AND PAYMENT (1) through (3) remain the same.

(4) Except as provided in (7) ~~of this rule~~, all Medicaid claims submitted to the department are to be submitted on a state claim form which is:

(a) through (16) remain the same.

(16) A person enrolled as an individual provider may not submit a claim for services that the provider did not personally provide, inclusive of services provided by another person under the provider's supervision, unless authorization to bill for and receive reimbursement for services the provider did not personally provide is stated in administrative rule or a Montana Medicaid program manual and is in compliance with any supervision requirements in state law or rule governing the provider's professional practice and the practice of assistants and aides. Other providers, including but not limited to hospitals, nursing facilities, and home health agencies, may bill for and receive reimbursement for services provided by supervised persons in accordance with the Medicaid rules and manual and any supervision requirements in state law or rule governing professional practice.

(17) through (20) remain the same.

~~(21) There is an emergency reimbursement reduction in effect for the following provider types for services provided January 10, 2003 through June 30, 2003:~~

~~(a) inpatient hospital;~~
~~(b) outpatient hospital;~~
~~(c) early periodic screening;~~
~~(d) diagnostic and treatment;~~
~~(e) nutritional services;~~
~~(f) chiropractic;~~
~~(g) podiatry;~~
~~(h) physical therapy;~~
~~(i) speech-language pathology;~~
~~(j) occupational therapy;~~
~~(k) audiology;~~

~~(l) optometry;~~
~~(m) public health clinic;~~
~~(n) dental;~~
~~(o) prosthetic devices;~~
~~(p) durable medical equipment and supplies;~~
~~(q) non-emergency transportation;~~
~~(r) ambulance;~~
~~(s) physician;~~
~~(t) ambulatory surgical center;~~
~~(u) non-hospital lab and x-ray;~~
~~(v) denturist;~~
~~(w) mid-level practitioner;~~
~~(x) qualified Medicare beneficiary (QMB) services;~~
~~(y) QMB chiropractic; and~~
~~(z) freestanding dialysis clinics.~~

~~(22) The net pay reimbursement for the provider types listed in (21) is 7% less than the amount provided in the following rules: ARM 37.83.811, 37.83.812, 37.83.825, 37.85.212, 37.86.105, 37.86.205, 37.86.506, 37.86.610, 37.86.705, 37.86.1004, 37.86.1005, 37.86.1406, 37.86.1806, 37.86.1807, 37.86.2005, 37.86.2207, 37.86.2209, 37.86.2211, 37.86.2405, 37.86.2505, 37.86.2605, 37.86.2801, 37.86.2904, 37.86.2905, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, 37.86.3005, 37.86.3006, 37.86.3007, 37.86.3009, 37.86.3011, 37.86.3014, 37.86.3016, 37.86.3018, 37.86.3020, 37.86.3022, 37.86.3205 and 37.86.4205.~~

~~(a) For purposes of this rule, "net pay reimbursement" means the allowed amount minus third party liability payments, copayments, coinsurance, incurments, and other deductions.~~

(21) The method of determining payment rates for provider based entities will be the same as for other professional and facility providers except as otherwise provided in [RULES I and IV].

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-131, 53-6-141, 53-6-149, MCA

37.86.105 PHYSICIAN SERVICES, REIMBURSEMENT/GENERAL REQUIREMENTS AND MODIFIERS (1) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained, in the ~~Health Care Financing Administration's~~ Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS). Information regarding billing codes, modifiers, and HCPCS is available upon request from the ~~Health Policy and Services~~ Health Resources Division at the address stated in ARM 37.86.101(3).

(2) through (2)(b) remain the same.

(3) Reimbursement for services of a psychiatrist, except as otherwise provided in this rule, is the lower of:

(a) remains the same.

(b) to address problems of access to mental health services, subject to funding, up to ~~125%~~ 150% of the reimbursement for physicians provided in accordance with the methodologies described in ARM 37.85.212.

(4) through (4)(b) remain the same.

(5) Reimbursement and claim completion instructions for Medicaid designated provider based entities are found in [RULES I and IV].

AUTH: 53-6-101, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, 53-6-141, MCA

37.86.205 MID-LEVEL PRACTITIONER SERVICES, REQUIREMENTS AND REIMBURSEMENT (1) remains the same.

(2) Medicaid coverage of mid-level practitioner services is available according to the requirements and procedures specified for physicians under ARM 37.86.101, 37.86.104, and 37.86.105.

(3) remains the same.

(4) Coverage of mid-level practitioner services is limited to the provision of services by the following providers:

(a) mid-level practitioners who are considered to have an independent employment status.;

(b) through (5)(b) remain the same.

(6) Reimbursement for immunizations, family planning services, administration of injectables, radiology, laboratory and pathology, cardiography and echocardiography services and for early and periodic screening, diagnostic and treatment services (EPSDT) is the lower of:

(a) remains the same.

(b) 100% of the reimbursement for physicians provided in accordance with the methodologies described in ARM 37.85.212 and 37.86.105.

(7) through (9)(g) remain the same.

(10) Reimbursement and claim completion instructions for Medicaid designated provider based entities are found in [RULES I and IV].

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, MCA

37.86.506 PODIATRY SERVICES, REIMBURSEMENT (1) remains the same.

(2) Reimbursement and claim completion instructions for Medicaid designated provider based entities are found in [RULES I and IV].

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-111, 53-6-131, 53-6-141, MCA

37.86.2801 ALL HOSPITAL REIMBURSEMENT, GENERAL

(1) through (2) remain the same.

(3) Medicaid reimbursement shall not be made unless the provider has obtained authorization from the department or its designated review organization

prior to providing any of the following services:

(a) remains the same.

~~(b) inpatient rehabilitation services;~~

~~(c)~~ (b) except as provided in (4) all inpatient ~~and outpatient hospital~~ services provided in preferred hospitals located more than 100 miles outside the borders of the state of Montana;

~~(d)~~ (c) services related to organ transplantations covered under ARM 37.86.4701 and 37.86.4705; or

~~(e)~~ (d) outpatient partial hospitalization, as required by ARM 37.88.101.

(4) Upon the request of a preferred hospital located more than 100 miles outside the borders of the state of Montana, the department may grant retroactive authorization for the provision of the hospital's services under the following circumstances only:

(a) remains the same.

(b) the hospital is retroactively enrolled as a Montana Medicaid provider, and the enrollment includes the dates of service for which authorization is requested; ~~or~~

(c) the hospital can document that at the time of admission it did not know, or have any basis to assume, that the patient was a Montana Medicaid client~~.~~; or

(d) the hospital can document that the admission was an emergency admit for purposes of stabilization or stabilization for transfer. The hospital must call for authorization within two working days (Monday through Friday) of the admission.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

37.86.2803 ALL HOSPITAL REIMBURSEMENT, COST REPORTING

(1) through (1)(c) remain the same.

(d) For cost report periods ending on or after January 1, 2006, for each hospital which is a critical access or exempt hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of ~~outpatient~~ hospital services shall be limited to 101% of allowable costs, as determined in accordance with (1).

(e) For cost report periods ending on or after January 1, 2007, for each hospital which is a preferred out-of-state hospital, as defined in ARM 37.86.2901, reimbursement for reasonable costs of inpatient hospital services shall be limited to 100% of allowable costs, as determined in accordance with (1).

(2) All hospitals reimbursed under ARM 37.86.2904, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, 37.86.2947, or 37.86.3005 must submit, as provided in (3), an annual Medicare cost report in which costs have been allocated to the Medicaid program as they relate to charges. The facility shall maintain appropriate accounting records which will enable the facility to fully complete the cost report.

(3) All hospitals reimbursed under ARM 37.86.2904, 37.86.2905, 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, 37.86.2924, 37.86.2925, 37.86.2947, or 37.86.3005 must file the cost report with the Montana Medicare intermediary and the department on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due

150 days after the last day of the cost reporting period.

(a) through (5) remain the same.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-149, MCA

37.86.2901 INPATIENT HOSPITAL SERVICES, DEFINITIONS

(1) "Administratively necessary days" or "inappropriate level of care services" means those services for which alternative placement of a patient is planned and/or effected and for which there is no medical necessity for acute level inpatient hospital care.

(2) "Bad debt" means inpatient and outpatient hospital services provided in which full payment is not received from the patient or from a third party payor, for which the provider expected payment and the persons are unable or unwilling to pay their bill. Bad debts may be for services provided to patients who have no health insurance or patients who are underinsured and are net of payments made toward these services. For the purpose of uncompensated care, bad debt is measured on the basis of revenue forgone, at full established rates, and bad debt does not include either provider discounts or Medicare bad debt.

~~(2)~~ (3) "Border hospital" means a hospital located outside Montana, but no more than 100 miles from the border.

(4) "Charity care" means inpatient and outpatient hospital services in which hospital policies determine the patient is unable to pay and did not expect to receive full reimbursement. Charity care results from a provider's policy to provide health care services free of charge (or where only partial payment is expected) to individuals who meet certain financial criteria. For the purpose of uncompensated care, charity care is measured on the basis of revenue forgone, at full established rates. Charity care does not include contractual write-offs.

~~(3)~~ (5) "Cost outlier" means an unusually high cost case that exceeds the cost outlier thresholds as set forth in ARM 37.86.2916.

~~(4)~~ (6) "Critical access hospital" means a limited-service rural hospital licensed by the Montana Department of Public Health and Human Services.

~~(5)~~ (7) "Direct nursing care" means the care given directly to the patient which requires the skills and expertise of an RN or LPN.

~~(6)~~ (8) "Discharging hospital" means a hospital, other than a transferring hospital, that formally discharges an inpatient. Release of a patient to another hospital, as described in ~~(21)~~ (24) or a leave of absence from the hospital will not be recognized as a discharge. A patient who dies in the hospital is considered a discharge.

~~(7)~~ (9) "Distinct part rehabilitation unit" means a unit of an acute care general hospital that meets the requirements in 42 CFR 412.25 and 412.29 (1992).

~~(8)~~ (10) "DRG hospital" means a hospital reimbursed pursuant to the diagnosis related group (DRG) system. DRG hospitals are classified as such by the Centers for Medicare and Medicaid Services (CMS) in accordance with 42 CFR 412.

~~(9)~~ (11) "Exempt hospital" means, for purposes of determining whether a hospital is exempt from the prospective payment system under ARM 37.86.2905, an acute care hospital that is located in a Montana county designated on or before July

1, 1991 as continuum code 8 or continuum code 9 by the United States Department of Agriculture under its rural-urban continuum codes for metro and nonmetro counties.

~~(10)~~ (12) "Hospital reimbursement adjustor~~"~~ (HRA)" means a payment to a Montana hospital as specified in ARM 37.86.2928 and 37.86.2940.

~~(11)~~ (13) "Hospital resident" means a recipient who is unable to be cared for in a setting other than the acute care hospital as provided in ARM 37.86.2921.

~~(12)~~ (14) "Inpatient" means a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person generally is considered an inpatient if formally admitted as an inpatient with an expectation that the patient will remain more than 24 hours. The physician or other practitioner is responsible for deciding whether the patient should be admitted as an inpatient. Inpatient hospital admissions are subject to retrospective review by the Medicaid Peer Review Organization (PRO) to determine whether the inpatient admission was medically necessary for Medicaid payment purposes.

~~(13)~~ (15) "Inpatient hospital services" means services that are ordinarily furnished in a hospital for the care and treatment of an inpatient under the direction of a physician, dentist, or other practitioner as permitted by federal law, and that are furnished in an institution that:

(a) is maintained primarily for the care and treatment of patients with disorders other than:

(i) tuberculosis; or

(ii) mental diseases, except as provided in ~~(12)(d)~~ (15)(d);

(b) is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located;

(c) except as otherwise permitted by federal law, meets the requirements for participation in Medicare as a hospital and has in effect a utilization review plan that meets the requirements of 42 CFR 482.30; or

(d) provides inpatient psychiatric hospital services for individuals under age 21 pursuant to ARM Title 37, chapter 88, subchapter 11.

~~(14)~~ (16) "Low income utilization rate" means a hospital's percentage rate as specified in ARM 37.86.2935.

~~(15)~~ (17) "Medicaid inpatient utilization rate" means a hospital's percentage rate as specified in ARM 37.86.2932.

(18) "Preferred out-of-state hospital" means a hospital located more than 100 miles outside the borders of Montana that has signed a contract with the department to provide specialized services prior approved by the department.

~~(16)~~ (19) "Qualified rate adjustment payment" (QRA) means an additional payment as provided in ARM 37.86.2910 to a county owned, county operated, or partially county funded rural hospital in Montana where the hospital's most recently reported costs are greater than the reimbursement received from Montana Medicaid for inpatient care.

~~(17)~~ (20) "Routine disproportionate share hospital" means a hospital in Montana which meets the criteria of ARM 37.86.2931.

~~(18)~~ (21) "Rural hospital" means for purposes of determining disproportionate share hospital payments, an acute care hospital that is located within a "rural area" as defined in 42 CFR 412.62(f)(iii).

~~(19)~~ (22) "Sole community hospital" means a DRG reimbursed hospital classified as such by the Centers for Medicare and Medicaid Services (CMS) in accordance with 42 CFR 412.92(a) through (d) and/or hospitals with less than 51 beds.

~~(20)~~ (23) "Supplemental disproportionate share hospital" means a hospital in Montana which meets the criteria in ARM 37.86.2925.

~~(21)~~ (24) "Transferring hospital" means a hospital that formally releases an inpatient to another inpatient hospital or inpatient unit of a hospital.

(25) "Uncompensated care" means hospital services provided in which no payment is received from the patient or from a third party payor. Uncompensated care includes charity care and bad debts.

~~(22)~~ (26) "Urban hospital" means an acute care hospital that is located within a metropolitan statistical area, as defined in 42 CFR 412.62(f)(2).

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, 53-6-149, MCA

37.86.2905 INPATIENT HOSPITAL SERVICES, GENERAL REIMBURSEMENT (1) Except as provided in (2), which is applicable to exempt hospitals, preferred out-of-state hospitals, ~~and~~ critical access hospitals (CAH), ~~in-state~~ and inpatient hospital service providers, including inpatient rehabilitation services and services in a setting that is identified by the department as a distinct rehabilitation unit, will be reimbursed under the DRG prospective payment system described in ARM 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, and 37.86.2924.

(2) Exempt hospital, preferred out-of-state hospitals, and CAH interim reimbursement is based on a hospital specific Medicaid inpatient cost to charge ratio, not to exceed 100%. Exempt hospitals, preferred out-of-state hospitals, and CAHs will be reimbursed their ~~actual~~ allowable costs as determined according to ARM 37.86.2803.

(3) Preferred out-of-state hospitals must sign individual agreements with the department agreeing to reimbursement requirements under ARM 37.86.2947 and prior authorization requirements under ARM 37.86.2801.

(a) Preferred out-of-state hospitals must agree to all department rules applicable to inpatient hospital providers.

~~(3)~~ (4) Except as otherwise specified in these rules, facilities reimbursed under the DRG prospective payment system may be reimbursed, in addition to the prospective DRG rate, for the following:

(3)(a) through (3)(i) remain the same but are renumbered (4)(a) through (4)(i).

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

37.86.2912 INPATIENT HOSPITAL PROSPECTIVE REIMBURSEMENT, CAPITAL-RELATED COSTS (1) remains the same.

(2) Prior to settlement based on audited costs, the department will make interim payments for each facility's capital-related costs as follows:

(a) remains the same.

(b) All border and out-of-state hospitals that are reimbursed under the DRG prospective payment system will be paid the statewide average capital cost per ~~case~~ claim as a~~n interim~~ final capital-related cost payment. The statewide average capital cost per ~~case~~ claim is ~~$229~~ $336. ~~This rate shall be the final capital-related cost with respect to which the department waives retrospective cost settlement in accordance with these rules.~~

(c) The department will make interim capital add-on payments with each in-state DRG inpatient hospital claim paid.

(d) The interim payment made to CAH and exempt facilities is based on the hospital specific cost to charge ratio and includes capital costs.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2918 INPATIENT HOSPITAL, READMISSIONS AND TRANSFERS

(1) through (3)(a) remain the same.

(4) Outpatient hospital services, including provider based entity hospital outpatient services, other than diagnostic services that are provided within the 24 hours preceding the inpatient hospital admission must be bundled into the inpatient claim.

(5) Diagnostic services (including clinical diagnostic laboratory tests) provided in any outpatient hospital setting including provider based entities within 72 hours prior to the date of admission are deemed to be inpatient services and must be bundled into the inpatient claim.

AUTH: 2-4-201, 53-2-201, 53-6-113, MCA
IMP: 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2943 BORDER INPATIENT HOSPITAL REIMBURSEMENT

(1) Inpatient hospital services provided in border hospitals will be reimbursed under the DRG prospective payment system described in ARM 37.86.2907, 37.86.2912, 37.86.2914, 37.86.2916, 37.86.2918, 37.86.2920, and 37.86.2924.

(2) In addition to the prospective rate, border hospitals will be reimbursed for cost outliers as set forth in ARM 37.86.2916, and for capital costs as set forth in ARM 37.86.2912, but shall not be reimbursed in addition to the DRG payment ~~for medical education costs, neonatal intensive care stop-loss reimbursement or certified registered nurse anesthetist costs~~ under ARM 37.86.2810, 37.86.2914, 37.86.2924, 37.86.2925, 37.86.2928, 37.86.2931, 37.86.2932, 37.86.2935, and 37.86.2940.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.2947 OUT-OF-STATE INPATIENT HOSPITAL REIMBURSEMENT

(1) Inpatient hospital services provided in hospitals located more than 100 miles outside the borders of the state of Montana ~~will be reimbursed 50% of usual~~

~~and customary billed charges for medically necessary services~~ shall receive reimbursement as follows:

(a) Preferred out-of-state hospitals will be reimbursed hospital specific inpatient cost to charge ratio on interim.

(b) Preferred out-of-state hospitals will be reimbursed 100% of their allowable costs determined according to ARM 37.86.2803.

(c) All other out-of-state hospitals shall receive DRG reimbursement as in ARM 37.86.2907.

(i) In addition to the prospective rate, out-of-state DRG hospitals will be reimbursed for cost outliers as set forth in ARM 37.86.2916, and for capital costs as set forth in ARM 37.86.2912, but shall not be reimbursed in addition to the DRG payment under ARM 37.86.2810, 37.86.2914, 37.86.2924, 37.86.2925, 37.86.2928, 37.86.2931, 37.86.2932, 37.86.2935, and 37.86.2940.

(ii) All out-of-state hospitals that are reimbursed under the DRG prospective payment system will be paid the statewide average capital cost per claim as a final capital-related cost payment. The statewide average capital cost per claim is $336.

(2) Preferred out-of-state and DRG out-state-hospitals shall not be reimbursed under ARM 37.86.2810, 37.86.2914, 37.86.2924, 37.86.2925, 37.86.2928, 37.86.2931, 37.86.2932, 37.86.2935, and 37.86.2940.

~~(2)~~ (3) Medicaid reimbursement for inpatient services for preferred out-of-state hospitals shall not be made to hospitals located more than 100 miles outside the borders of Montana unless the provider has obtained authorization from the department or its designated review organization prior to providing services. All inpatient services provided in an emergent situation must be authorized within ~~48 hours~~ two working days (Monday through Friday).

(a) Hospitals who have not obtained prior authorization under ARM 37.86.2801(4) may receive DRG reimbursement which is not eligible for cost settlement under ARM 37.86.2803.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3001 OUTPATIENT HOSPITAL AND BIRTHING CENTER SERVICES, DEFINITIONS (1) "Ambulatory payment classification (APC)" means Medicare's ambulatory payment classification assignment groups of CPT or HCPCS codes.

(2) "Bad debt" means inpatient and outpatient hospital services provided in which full payment is not received from the patient or from a third party payor, for which the provider expected payment and the persons are unable or unwilling to pay their bill. Bad debts may be for services provided to patients who have no health insurance or patients who are underinsured and are net of payments made toward these services. For the purpose of uncompensated care, bad debt is measured on the basis of revenue forgone, at full established rates, and bad debt does not include either provider discounts or Medicare bad debt.

(3) "Birthing center" means a licensed outpatient center for primary care with medical resources as defined at 50-5-101, MCA, that is used as an alternative to a homebirth or a hospital birth.

(4) "Charity care" means inpatient and outpatient hospital services in which hospital policies determine the patient is unable to pay and did not expect to receive full reimbursement. Charity care results from a provider's policy to provide health care services free of charge (or where only partial payment is expected) to individuals who meet certain financial criteria. For the purpose of uncompensated care, charity care is measured on the basis of revenue forgone, at full established rates. Charity care does not include contractual write-offs.

~~(2)~~ (5) "Conversion factor" means an adjustment equal to Medicare's highest urban rate for Montana as published at 67 Federal Register (FR) 43616 (June 28, 2002).

~~(3)~~ (6) "Diagnostic service" means an examination or procedure performed on an outpatient or on materials derived from an outpatient to obtain information to aid in the assessment or identification of a medical condition.

~~(4)~~ (7) "Full-day partial hospitalization program" means a partial hospitalization program providing services at least six hours per day, five days per week.

~~(5)~~ (8) "Half-day partial hospitalization program" means a partial hospitalization program providing services for at least four but less than six hours per day, at least four days per week.

~~(6)~~ (9) "Healthcare common procedures coding system (HCPCS)" means the national uniform coding method maintained by the Centers for Medicare and Medicaid Services (CMS) that incorporates the American Medical Association (AMA) Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels, I, II, and III.

~~(7)~~ (10) "ICD-9-CM" means the International Classification of Diseases, Ninth Revision based on the official version of the United Nations World Health Organization's Ninth Revision.

~~(8)~~ (11) "Imaging service" means diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging services, ultra-sound, and other imaging procedures.

~~(9)~~ (12) "Outpatient" means a person who:

(a) has not been admitted by a hospital or birthing center as an inpatient;

(b) is expected by the hospital or birthing center to receive services in the hospital for less than 24 hours;

(c) is registered on the hospital or birthing center records as an outpatient; and

(d) receives outpatient ~~hospital~~ services from the hospital or birthing center, other than supplies or drugs alone, for nonemergency medical conditions.

~~(10)~~ (13) "Outpatient hospital services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner as permitted by federal law, by an institution that:

(a) is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and

(b) except as otherwise permitted by federal law, meets the requirements for participation in Medicare as a hospital.

~~(11)~~ (14) "Outpatient prospective payment system~~"~~ (OPPS)" means

Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

(12) through (12)(d) remain the same but are renumbered (15) through (15)(d).

(16) "Provider-based entity" means a provider that is either created by, or acquired by, a main provider for purposes of furnishing health care services under the name, ownership, and administrative and financial control of the main provider as in 42 CFR 413.65. Both professional and facility (hospital outpatient department) providers are included together under this definition.

~~(13)~~ (17) "Qualified rate adjustment~~"~~ (QRA)" payment means an additional payment to a county owned, operated, or partially county funded rural hospital in Montana as provided in ARM 37.86.3005, when the hospital's most recently reported costs are greater than the reimbursement received from Montana Medicaid for outpatient care.

(18) "Uncompensated care" means hospital services provided in which no payment is received from the patient or from a third party payer. Uncompensated care includes charity care and bad debts.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

37.86.3005 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT AND QUALIFIED RATE ADJUSTMENT PAYMENT (1) The department will reimburse for outpatient hospital services and birthing center services compensable under the Montana Medicaid program as provided in this rule.

(2) Outpatient hospital services that are not provided by exempt hospitals or critical access hospitals as defined in ARM 37.86.2901 will be reimbursed under ARM 37.86.3007, 37.86.3009, 37.86.3016, 37.86.3018, 37.86.3020, ~~and~~ 37.86.3025, 37.86.3109, and [RULE IV] for medically necessary services.

(3) Birthing center services as defined in ARM 37.86.3001 will be reimbursed under ARM 37.86.3007, 37.86.3016, 37.86.3018, and 37.86.3020, for medically necessary services.

~~(3)~~ (4) For critical access hospitals and exempt hospitals, interim reimbursement for outpatient hospital services is based on hospital specific Medicaid outpatient cost to charge ratio, not to exceed 100%. Critical access hospitals and exempt hospitals will be reimbursed their actual allowable costs determined according to ARM 37.86.2803. ~~If a provider fails or refuses to submit the financial information, including the Medicare cost report, necessary to determine the cost to charge ratio, the provider's interim rate will be 50% of its usual and customary charges (billed charges).~~

~~(4)~~ (5) Subject to the availability of sufficient county and federal funding, the department will pay in addition to the established Medicaid rates provided in this rule a qualified rate adjustment payment to an eligible rural hospital in Montana as provided in ARM 37.86.2810.

AUTH: 53-2-201, 53-6-113, MCA

IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA

37.86.3007 OUTPATIENT HOSPITAL AND BIRTHING CENTER SERVICES, PROSPECTIVE PAYMENT METHODOLOGY, CLINICAL DIAGNOSTIC LABORATORY SERVICES (1) Clinical diagnostic laboratory services, including automated multichannel test panels (commonly referred to as "ATPs") and lab panels, will be reimbursed on a fee basis as follows with the exception of hospitals reimbursed under ARM 37.86.3005 and specific lab codes which are paid under ARM 37.86.3020:

(a) The fee for a clinical diagnostic laboratory service is the ~~lesser of the provider's usual and customary charge (billed charges) or the~~ applicable percentage of the Medicare fee schedule as follows:

(i) 60% of the prevailing Medicare fee schedule for a birthing center or where a hospital laboratory acts as an independent laboratory, i.e., performs tests for persons who are nonhospital patients;

(ii) and (iii) remain the same.

(b) For clinical diagnostic laboratory services~~:~~

~~(i)~~ where no Medicare fee has been assigned, ~~the fee is 62% of usual and customary charges (billed charges) for a hospital designated as a sole community hospital as defined in ARM 37.86.2901 or 60% of usual and customary charges (billed charges) for a hospital that is not designated as a sole community hospital as defined in ARM 37.86.2901~~ but a Medicaid fee has been assigned, the fee is the amount set in ARM 37.85.212; or

~~(ii)~~ (c) ~~if a Medicaid fee has been assigned, the fee is the amount set in ARM 37.85.212(9)~~ if there is no Medicare or Medicaid fee, the service will be reimbursed at hospital specific outpatient cost to charge ratio as in ARM 37.86.2803. Birthing centers will be reimbursed the statewide outpatient cost to charge ratio.

~~(c)~~ (2) For purposes of this rule, clinical diagnostic laboratory services include the laboratory tests listed in codes defined in the HCPCS and listed in the Clinical Diagnostic Fee Schedule (CLAB) published December 14, 2005.

~~(d)~~ (3) Specimen collection will be reimbursed separately for drawing a blood sample through venipuncture or for collecting a urine sample by catheterization. Specimen collection will be reimbursed as specified in the department's outpatient fee schedule as adopted in ARM 37.86.3025, whether or not the specimens are referred to physicians or other laboratories for testing. No more than one collection fee may be allowed for each patient visit, regardless of the number of specimens drawn.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3009 OUTPATIENT HOSPITAL SERVICES, PAYMENT METHODOLOGY, EMERGENCY VISIT SERVICES ~~(1) Emergency visits are emergency room services for which the ICD-9-CM presenting diagnosis code (admitting diagnosis code) or the diagnosis code (primary or secondary diagnosis code) chiefly responsible for the services provided is a diagnosis designated by the department as an emergency diagnosis in the Medicaid emergency diagnosis list or~~

~~the claim includes a CPT code designated by the department as an emergency procedure code. Passport provider authorization is not required for these visits. For purposes of this rule, the department adopts and incorporates by reference the Emergency Diagnosis and Procedure Code List effective January 1, 2005. The Emergency Diagnosis and Procedure Code List is available upon request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.~~

~~(2)~~ (1) For emergency visits that are not provided by exempt hospitals or critical access hospitals as defined in ARM 37.86.2901 ~~and meet (1)~~, reimbursement will be based on the ambulatory payment classifications APC methodology in ARM 37.86.3020, (except) ~~for~~ emergency room visits ~~on evenings and weekends for Medicaid clients from birth to 24 months of age~~ with CPT codes 99281 and 99282 will be reimbursed based on clinical fees for APC 00600.

(a) Passport to Health provider authorization is not required for emergency room visits. ~~Evenings are defined as from 6 p.m. on Monday, Tuesday, Wednesday, and Thursday until 8 a.m. of the following day.~~

~~(b) Weekends are defined as from 6 p.m. Friday until 8 a.m. on Monday.~~

~~(3) For emergency visits not meeting (1), reimbursement will be a prospective fee for evaluation and stabilization as specified in the department's outpatient fee schedule plus ancillary reimbursement for laboratory, imaging and other diagnostic services not included in the APR reimbursement. The evaluation and stabilization fee is considered payment in full.~~

~~(4) An evaluation and stabilization fee is an all inclusive bundled payment per visit which covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, supplies, equipment, and other outpatient hospital services.~~

~~(5)~~ (2) Physician services are separately billable according to the applicable rules governing billing for physician services.

~~(6) For emergency visits which the medical professional rendering the screening and evaluation determine are emergent but not on the department's emergency list, a hospital may send the claim and emergency room documentation for review to the department for payment of a fee other than the evaluation and stabilization fee.~~

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3016 OUTPATIENT HOSPITAL AND BIRTHING CENTER SERVICES, PROSPECTIVE PAYMENT METHODOLOGY, IMAGING SERVICES

(1) Imaging services will be reimbursed ~~as in ARM 37.86.3020~~ with the exception of hospitals reimbursed under ARM 37.86.3005(3) ~~and except~~ as follows:

(a) For each imaging service or procedure, the fee will be the ~~lesser of the provider's usual and customary charges (billed charges) or 100% of the Medicare~~ APC rate as in ARM 37.86.3020 or Medicare fee if no APC rate exists. The imaging services reimbursed under this subsection are the individual imaging service codes defined in the CPT/HCPCS.

(b) For imaging services where no APC rate or Medicare fee has been

assigned, ~~the fee is 62% of usual and customary charges (billed charges) for a hospital designated as a sole community hospital as defined in ARM 37.86.2901 or 60% of usual and customary charges (billed charges) for a hospital that is not designated as a sole community hospital as defined in ARM 37.86.2901~~ a Medicaid fee will be set in accordance with the resource based relative value scale (RBRVS) methodology found at ARM 37.86.212.

(c) For imaging services where no APC rate, Medicare fee or Medicaid fee has been assigned, outpatient hospital-specific percent of charges will be paid. Birthing centers will be reimbursed the statewide outpatient cost to charge ratio.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3018 OUTPATIENT HOSPITAL AND BIRTHING CENTERS SERVICES, PROSPECTIVE PAYMENT METHODOLOGY, OTHER DIAGNOSTIC SERVICES (1) Other diagnostic services will be reimbursed as follows with the exception of hospitals reimbursed under ARM 37.86.3005(3):

(a) ~~the lesser of the provider's usual and customary charges (billed charges) or 100% of~~ the fee will be the ~~Medicare~~ APC rate as in ARM 37.86.3020 or the Medicare fee for the same service if no APC rate exists. The individual diagnostic services reimbursed under this subsection are those defined in the CPT/HCPCS;

~~(b) other diagnostic services without a Medicare APC rate and for which no Medicare APC rate has been assigned will be reimbursed under the retrospective cost basis as specified in ARM 37.86.3005(3); or~~

~~(c)~~ (b) for other diagnostic services without an APC rate or Medicare fee, ~~but for which~~ a Medicaid fee ~~has been~~ will be assigned~~, the fee will be set~~ in accordance with the RBRVS methodology in ARM 37.85.212~~.~~; or

(c) for other diagnostic services where no APC rate, Medicare fee, or Medicaid fee has been assigned, outpatient hospital specific percent of charges will be paid. Birthing centers will be reimbursed the statewide outpatient cost to charge ratio.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3020 OUTPATIENT HOSPITAL AND BIRTHING CENTER SERVICES, OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) METHODOLOGY, AMBULATORY PAYMENT CLASSIFICATION (1) Outpatient hospital or birthing center services that are not provided by exempt hospitals or critical access hospitals as defined in ARM 37.86.2901(4) and (8) will be reimbursed on a rate-per-service basis using the Outpatient Prospective Payment System (OPPS) schedules. Under this system, Medicaid payment for ~~hospital~~ outpatient services included in the OPPS is made at a predetermined, specific rate. These outpatient services are classified according to a list of APCs published annually in the Code of Federal Regulations (CFR). The rates for OPPS are determined as follows:

(a) The department uses a conversion factor for each APC group as defined

at ARM 37.86.3001(2). The APC based fee equals the Medicare specific relative weight for the APC times the conversion factor that is the same for all APCs with the exceptions of services in ARM 37.86.3025. APCs are based on classification assignment of CPT/HCPCS codes.

(b) remains the same.

(c) APCs are an all inclusive bundled payment per visit which covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, laboratory, imaging services, other diagnostic services, supplies and equipment, and other outpatient services. For purposes of OPPS, a visit includes all outpatient hospital or birthing center services related or incident to the outpatient visit that are provided the day before or the day of the outpatient visit.

(d) remains the same.

(e) If the OPPS does not assign a Medicare fee or APC for a particular procedure code, ~~but for which~~ a Medicaid fee ~~has been~~ will be assigned~~, the fee will be set~~ in accordance with the resource based relative value scale (RBRVS) methodology found at ARM 37.85.212. If there is not a Medicaid fee, the service will be reimbursed at hospital specific outpatient cost to charge ratio as in ARM 37.86.2803. Birthing centers will be reimbursed the statewide outpatient cost to charge ratio.

~~(i) If a provider fails or refuses to submit the financial information, including the Medicare cost report, necessary to determine the cost to charge ratio, the provider's reimbursement will be 50% of its usual and customary charges (billed charges).~~

(f) and (f)(i) remain the same.

(g) The department follows Medicare guidelines for procedures defined as "inpatient only". When these procedures are performed in the outpatient hospital or birthing center setting, the claim will be denied.

(h) remains the same.

(2) The department adopts and incorporates by reference the OPPS Schedules published by the Centers for Medicare and Medicaid Services (CMS) in ~~70 Federal Register 217 , November 10, 2005,~~ 71 Federal Register 163, August 23, 2006, proposed effective date January 1, ~~2006~~ 2007. A copy may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.86.3025 OUTPATIENT HOSPITAL SERVICES, REIMBURSEMENT FOR SERVICES NOT PAID UNDER THE AMBULATORY PAYMENT CLASSIFICATION SYSTEM (1) Therapy services will be paid 90% of the reimbursement provided in accordance with the RBRVS methodologies in ARM 37.85.212. Therapy services include physical therapy, occupational therapy, and speech-language pathology and are subject to requirements and restrictions as in ARM 37.86.606.

(2) through (4)(b) remain the same.

(5) Professional services, except as in ~~(6) and (7)~~ [RULE I and IV], must bill separately on a professional billing form according to applicable rules governing

billing for professional services.

~~(6) For services provided on or after August 1, 2003, hospitals receiving a provider based status from CMS must send a copy of the CMS letter granting provider based status to the department's hospital program officer at Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951 and must receive department approval prior to billing as a provider based clinic.~~

~~(a) Physicians, mid-levels, and other professionals billing for services on a professional billing form for services provided in a provider based clinic must show hospital outpatient as the place of service on the claim and will receive payment as in ARM 37.86.105(2).~~

~~(b) Physicians, mid-levels, and other professionals providing services that have both a professional and technical component in a provider based clinic may bill only for the professional component of the service. The technical component shall be billed under the hospital's provider number using the appropriate coding and modifiers.~~

~~(c) Hospitals granted a provider based status by the department may not restrict access to Medicaid clients.~~

~~(7)~~ (6) Interim payment for certified registered nurse anesthetists (CRNAs) will be reimbursed at hospital specific outpatient cost to charge ratio and settled as a pass through in the cost settlement, as provided in ARM 37.86.2924.

~~(8)~~ (7) The department adopts and incorporates by reference the Outpatient Hospital Fee Schedule dated January 1, ~~2005~~ 2007. A copy may be obtained through the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

37.88.206 LICENSED CLINICAL SOCIAL WORK SERVICES, REIMBURSEMENT (1) Providers must bill for covered services using the procedure codes and modifiers set forth and according to the definitions contained in the ~~health care financing administration's~~ CMS's Healthcare Common Procedure Coding System (HCPCS). Information regarding billing codes, modifiers, and HCPCS is available upon request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) through (2)(a)(ii) remain the same.

(3) Reimbursement and claim completion instructions for Medicaid designated provider based entities are found in [RULE I and IV].

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, MCA

37.88.306 LICENSED PROFESSIONAL COUNSELOR SERVICES, REIMBURSEMENT (1) Providers must bill for covered services using the procedure codes and modifiers set forth, and according to the definitions contained,

in the ~~health care financing administration's~~ CMS's Healthcare Common Procedure Coding System (HCPCS). Information regarding billing codes, modifiers and HCPCS is available upon request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) through (2)(a)(ii) remain the same.

(3) Reimbursement and claim completion instructions for Medicaid designated provider based entities are found in [RULES I and IV].

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, MCA

37.88.606 LICENSED PSYCHOLOGIST SERVICES, REIMBURSEMENT

(1) Providers must bill for covered services using the procedure codes and modifiers set forth and according to the definitions contained in the ~~health care financing administration's~~ CMS's Healthcare Common Procedure Coding System (HCPCS). Information regarding billing codes, modifiers, and HCPCS is available upon request from the Department of Public Health and Human Services, Health Resources Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(2) through (2)(a)(ii) remain the same.

(3) Reimbursement and claim completion instructions for Medicaid designated provider based entities are found in [RULE I and IV].

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-6-101, 53-6-113, MCA

37.88.1106 INPATIENT PSYCHIATRIC SERVICES, REIMBURSEMENT

(1) through (3)(b) remain the same.

(4) Reimbursement for inpatient psychiatric services provided to Montana Medicaid recipients in facilities located outside the state of Montana will be ~~as provided in ARM 37.86.2905~~ reimbursed 50% of usual and customary billed charges for medically necessary services.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA

4. The Department of Public Health and Human Services (the department) is proposing new Rules I through IV and the amendment of ARM 37.85.406, 37.86.105, 37.86.205, 37.86.506, 37.86.2801, 37.86.2803, 37.86.2901, 37.86.2905, 37.86.2912, 37.86.2918, 37.86.2947, 37.86.2943, 37.86.3001, 37.86.3005, 37.86.3007, 37.86.3009, 37.86.3016, 37.86.3018, 37.86.3020, 37.86.3025, 37.88.206, 37.88.606, and 37.88.1106 pertaining to Medicaid reimbursement of hospitals, provider based entities and birthing centers. The department has several goals it wishes to accomplish with this rule change:

The department proposes to add federal definitions of uncompensated and charity care and bad debt to Montana rules for cost reporting purposes. Montana has always used the federal definitions. There is no monetary effect to this change.

Statewide average capital cost per case is used as a reimbursement for border facilities. We are adding this as a reimbursement to our new out-of-state facilities. This add-on payment has increased to $336. This change is estimated to cost $11,800 per year.

The department is changing its inpatient reimbursement methodology for out-of-state hospitals. Out-of-state facilities are being divided into two types of facilities, Prospective Payment System (PPS) and those paid by cost. This change will save the department $1,300,000 per year.

The department is changing its criteria for determining how services are reimbursed for emergency room services. This change will increase reimbursement to providers by about $896,000 per year.

Coverage of provider based entity services were added in August 2003. The department is taking this opportunity to clearly define what a provider based entity is, what rules apply to these entities, and to change reimbursement. This change will save the department $355,000 per year.

The department is defining birthing centers and their coverage, and adding reimbursement of a facility fee to these centers. It is difficult to measure this impact. The difference between the professional and facility inpatient reimbursement for uncomplicated deliveries, $4,508, and professional and facility reimbursement, $3,242, is $1,266 per delivery.

The department is rewriting the rules for lab, imaging, and diagnostic services while it adds these services for birthing centers. The language in the previous rules made it difficult for providers to understand the payment methodologies for these services.

The Children's Mental Health Bureau does not want to change the reimbursement structure of out-of-state Residential Treatment Facilities; therefore, to maintain clarity we are changing the rule to reflect our current reimbursement structure.

The department is also taking this opportunity to update terms and to conform the rules to current format. No substantive effect is intended by such amendments.

ARM 37.86.2803 and 37.86.3001

The department is adding the United States Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) definitions of uncompensated care, charity care and bad debt to both the inpatient and outpatient hospital definition rules. These definitions are used for cost reporting and upper payment limits for the hospital provider assessment. The department has used

these definitions for many years in its calculations. Adding the definitions to rule was a request by CMS. This has no financial impact on facilities.

ARM 37.86.2912, 37.86.2943, and 37.86.2947

The department is raising the statewide average capital cost per claim to $336. This is an increase of $107 per claim. The department will also make this payment to the newly designated out-of-state PPS facilities. This is a final payment. Capital for border and out-of-state PPS facilities will not be cost settled. The department is also stating in rule a long held practice of reimbursing Critical Access Hospital (CAH) and Exempt facilities, capital costs as part of their interim cost to charge ratio, and including capital in their final cost settlements. This change will have a financial impact on approximately 110 claims per year at a cost to the department of $11,800.

ARM 37.86.2801, 37.86.2803, 37.86.2901, 37.86.2905, and 37.86.2947

The department deals with approximately 125 out-of-state facilities per year for both outpatient and inpatient services. The majority of these are one time only visits for outpatient emergency services or inpatient births. Generally only 45 of these facilities provide inpatient services with ten providing the vast majority of the services on a regular basis. The services provided by these facilities are usually cancer, burn, trauma, transplant, or surgical services (primarily neonatal and pediatric) that cannot be provided at a Montana facility. Since March 2002, the department has required prior authorization and reimbursed all out-of-state inpatient services at 50% of charges with no cost settlement. At that time 50% was an aggregate cost to charge ratio for the majority of the out-of-state facilities that the department dealt with on a regular basis.

In some cases, out-of-state facilities have refused to accept Montana Medicaid payment unless the department signs an exclusive contract with them for the service. Some Montana facilities have made reciprocal agreements with specialty hospitals in other states in order to provide coverage for those subspecialties that are not available in Montana at this time. Under current rule we are not able to negotiate any cost based payment to these facilities.

The department recently requested cost reports from the largest out-of-state facilities and discovered the aggregate cost to charge ratio has changed. In addition, the prior authorization requirement has caused some facilities who do not have experience with Montana's rules to not receive reimbursement for medically necessary services that could not have been provided in Montana.

After analysis, the department has decided to break out-of-state facilities into two groups for inpatient reimbursement and prior authorization purposes. The majority of the 45 inpatient facilities, which provide one time services that could have been provided in Montana will be treated as PPS facilities and reimbursed instate Diagnostic Related Groups (DRGs). The other facilities will be deemed "preferred hospitals" and will be reimbursed hospital specific cost to charge ratios on the

interim and cost settled. Preferred facilities will have to request prior authorization of services so the department may determine that the services are not available in Montana. Preferred facilities will be required to sign contracts with the department agreeing to abide by all other medical provider rules and regulations. The department will then coordinate approval of hospital, transportation, Passport to Health and any other authorizations necessary for these services. Should the facility for some reason not obtain prior authorization under these rules the department will still offer them the opportunity to request reimbursement. Reimbursement without prior authorization will be the instate DRG payment and will not be subject to cost settlement.

The department examined and rejected several other reimbursement options. This option will enable the department to not only save money but to insure the delivery of medically necessary services that are not available under other circumstances to Montana Medicaid recipients. This rule change is estimated to save the department $1,300,000 per year.

ARM 37.86.3009

Currently the department reimburses emergency room visits that do not meet the definition of "emergency medical conditions" a screening and evaluation fee and for any diagnostics necessary to determine an emergency medical condition. All other services on the claim are paid at "$0.00". After analysis, the department has concluded that, in fact, the majority of emergency department visits do not meet the definition of an "emergency medical condition". These visits are generally coded with CPT codes 99281 or 99282. These visits amount to the same thing as a clinic visit. Because the current procedure for determining if a visit is an "emergency medical condition" is cumbersome on both the department and the provider, the department has decided to change the rules to reimburse all services provided in an emergency department (except for those in a CAH or Exempt facility) under the regular OPPS reimbursement policy, except those claims with codes 99281 and 99282. Instead of paying the higher emergency room fee for these codes, a clinic fee will be paid regardless of "emergency medical condition". The department will do regular retro reviews to make sure that facilities are not up-coding to receive higher reimbursement. The impact to hospital and department staff in the easing of the current review process has not been measured, however, it is acknowledged by all that it is substantial. The department worked with the hospitals and Emergency Department (ED) physicians to develop other methods of keeping ED costs down while at the same time eliminating the administrative burden of the current process. This choice was deemed to be the best of the various options. The monetary impact of this change is an increase in department reimbursement of $896,000 per year.

ARM 37.85.406, 37.86.105, 37.86.205, 37.86.506, 37.86.2918, 37.86.3025, 37.88.206, 37.88.606, and Rules I through IV

Coverage of provider based entity services were added August 2003. The department is taking this opportunity to clearly define what a provider based entity is,

what rules apply to these entities, and to change reimbursement.

These changes are to ARM 37.85.406, 37.86.105, 37.86.205, 37.86.506, 37.86.2918, 37.86.3025, 37.88.206, 37.88.606, and New Rules I through IV. In August 2003, Healthcare Financial Managers Association (HFMA) and Montana Hospital Association (MHA) asked the department to follow Medicare and allow for provider-based billing in order to insure access. They made the argument that hospital owned physician groups could decide to severely limit or not accept Medicaid patients and thus limit access in some parts of the state if we did not change our reimbursement methodology for these entities and follow Medicare.

Basically, this rule allows these facilities to bill an office visit as both a "technical" component on a UB, receiving an Ambulatory Payment Classification (APC) payment, and bill for the "professional" component on a 1500, receiving a Resource Based Relative Value System (RBRVS) payment for site differential "facility" instead of receiving a RBRVS payment for office place of service. By nature the facility site of service payment is the lower.

One of the new provider-based facilities recently explained to the department how their status as a provider-based facility has allowed for more access to Medicaid recipients. There are two large family practice clinics in the community. Over the past year one of the clinics has refused to accept any new Medicaid recipients over the age of five. In addition, current adult Medicaid recipients of this clinic are reporting to the hospitals ED that they are having trouble getting timely appointments. By joining forces with the hospital, the provider-based clinic has been able to add more staff and change their hours of operation to better accommodate appointments for Medicaid recipients.

Analysis by the department, however, has determined that there are several of the now 13 provider based entities that are in fact not accepting Medicaid patients. In addition it has been determined that current provider based entity reimbursement is 39.2% higher than reimbursement in a physician clinic. The department looked at various other options including elimination of provider based reimbursement, allowing only billing of the professional component with a slight raise in RBRVS reimbursement or a 50% reduction to the technical portion. It was decided the option chosen by the department would have the least impact. The other proposed provider based rules, with the exception of Passport to Health enrollment, are the same rules used by Medicare and so will have no impact on current billing practices. The proposed requirement of Passport to Health enrollment is to insure access for Medicaid recipients.

The department has made the choice to continue provider based entity reimbursement. However, it is taking this opportunity to clearly establish rules regarding allowed services, access issues, and billing practices. In addition, the department is cutting reimbursement to the technical portion of the evaluation and management and procedural portions of the facility payment by 20%. This is a 10.8% reduction in reimbursement to the current rate received by these entities, yet

it is still 38.4% more than any other physician practice receives from Montana Medicaid. The budget impact of this change is a savings to the department of $335,000 per year.

ARM 37.86.3001, 37.86.3005, 37.86.3007, 37.86.3009, 37.86.3016, 37.86.3018, and 37.86.3020

The department is defining birthing centers and their coverage and adding reimbursement of a facility fee to these centers. Birthing centers are licensed as an "outpatient center for primary care". This allows a facility to provide, under the direction of a licensed physician, either diagnosis, treatment, or both, to ambulatory patients and the facility is not an outpatient center for surgical services.

Routine births may be reimbursed in a hospital outpatient setting where the patient is not expected to remain for 24 hours or more. Complicated deliveries are not reimbursable in an outpatient setting and must be inpatient only. Reimbursement for normal deliveries with no complications is under the OPPS APC payment methodology. Physician reimbursement is the same as if the newborn were delivered in an inpatient setting.

We propose reimbursing normal uncomplicated pregnancies and deliveries in birthing centers as we would any other outpatient delivery in a provider based facility. They would bill appropriate physician charges as usual and receive RBRVS reimbursement. Any diagnostic or lab services and the delivery would be billed on a facility claim form, once enrolled as an outpatient provider. Montana Medicaid reimburses for very few outpatient births each year in state (most are out-of-state emergency deliveries). The highest number has been 12 births in one year. The difference between the professional and facility inpatient reimbursement for uncomplicated deliveries ($4,508) and professional and birthing center facility reimbursement ($3,242) is $1,266 per delivery. There will be a savings to the department but it is difficult to determine the amount.

The department looked at various other reimbursement methodologies but determined that the proposed payment method best reflected the birthing services offered in an inpatient setting versus the services offered in an outpatient setting at a birthing center.

37.86.3020

Medicaid adopted Medicare's Outpatient Prospective Payment System (OPPS) August 2003. CMS annually updates Medicare Payment Rules for Outpatient Hospital Services for prospective payment hospitals January 1st of each year. The proposed changes to ARM 37.86.3020 or the rule, which includes updates to APC weights, editing, coding, and modifier changes, is published in August of each year and the final rule published in November of each year.

Changes for 2007 include removing and adding drug and biological codes, adding

inflation rates for some drug and biological prices, changing the brachytherapy source payment method from pass through to PPS, proposing modification to the method for coding clinic and emergency department visits, changes to the blood product table, and removing some codes from the inpatient only list. Medicaid has adopted Medicare's final rule each year since 2003 and will do so again for each calendar year starting January 1, 2007.

ARM 37.86.3007, 37.86.3016, and 37.86.3018

While adding coverage of lab, imaging, and other diagnostics for birthing centers, the department determined that these rules were difficult to follow and were not clearly written. The department is taking this opportunity to correct this. There is no monetary impact.

ARM 37.86.105

The department is correcting reimbursement for psychiatrists. This change was actually made July 1, 2005 but inadvertently left out of this rule. This rule change raises the rate of payment for psychiatrists from 125% of the RBRVS to 150%. Montana has a lack of psychiatrists statewide who will serve Medicaid individuals. This creates access problems for Medicaid recipients with mental health issues. Lack of community psychiatric care often results in institutionalization for longer term care. There is no budget impact as this has been in place two years and is now part of our base and our caseload.

37.88.1106

We are adjusting ARM 37.88.1106(4) to remove reference to 37.86.2905. ARM 37.86.2905 is being revised to reflect a change in the rate of reimbursement for out-of-state hospitals. Children's Mental Health Bureau does not want to change the reimbursement structure of out-of-state residential treatment facilities; therefore, to maintain clarity we are changing the rule to reflect our current reimbursement structure.

FISCAL IMPACT

Total changes:

SFY07 decrease in expenditures, Total SFY07=$373,600
SFY08 decrease in expenditures, Total SFY08=$747,200

Persons and entities affected

In Montana there are 42 critical access hospitals, two exempt hospitals, 37 DRG border hospitals, and 15 DRG hospitals eligible to receive Medicaid reimbursement. There are approximately 200 out-of-state hospitals eligible to receive Medicaid reimbursement.

The proposed changes to emergency room reimbursement affects all hospitals.

The proposed state-wide average capital cost per case increase affects border hospitals.

Proposed changes to out-of-state inpatient reimbursement affects all out-of-state hospitals.

There are 13 in-state provider based facilities and 26 out-of-state provider based facilities affected by this rule change.

There are currently two licensed birthing centers in Montana. Medicaid reimburses approximately 4,300 births per year with generally no more than 12 in an outpatient setting.

There are 21 out of state Residential Treatment Centers affected by this rule change.

There were approximately 75 in-state and 141 out-of-state psychiatrists affected by the increase in reimbursement correction.

5. Interested persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to Dawn Sliva, Office of Legal Affairs, Department of Public Health and Human Services, P.O. Box 4210, Helena, MT 59604-4210, no later than 5:00 p.m. on December 7, 2006. Data, views, or arguments may also be submitted by facsimile (406)444-1970 or by electronic mail via the Internet to dphhslegal@mt.gov. The department also maintains lists of persons interested in receiving notice of administrative rule changes. These lists are compiled according to subjects or programs of interest. For placement on the mailing list, please write the person at the address above.

6. The Office of Legal Affairs, Department of Public Health and Human Services, has been designated to preside over and conduct the hearing.

/s/ John Koch for
Rule Reviewer

/s/ John Chappuis for
Director, Public Health and Human Services

Certified to the Secretary of State October 30, 2006.